Executive Office of the President
Office of National Drug Control Policy

The Heroin Situation: A Status Report

ONDCP Bulletin, No. 5 **April 1992**

As the current cocaine epidemic in this country continues broadly to wane, some have speculated that the increasingly pure, available, and cheap supply of heroin in the United States might lead to significant increases in heroin consumption.

This Bulletin[1] reviews the evidence for and against significantly increased use and concludes that, although there may be some increase in the number of heroin users over the next few years, a massive increase in heroin use and addiction is not likely. This conclusion is based on three lines of evidence: growing societal intolerance of drug use generally, widespread stigmatization of heroin use specifically, and the apparent absence of new initiates (i.e., heroin users with little or no prior drug-using experience).

WARNING SIGNS OF A DRUG EPIDEMIC

Most authorities would agree that drug epidemics are facilitated by the presence of a number of conditions: the particular drug must be readily available, of high quality, affordable, and not perceived as addictive. Further, since new users are usually initiated to drugs by acquaintances, there must be a group of credible "peer influencers." These conditions are present in a societal environment of "drug tolerance" — such as occurred in this country from the 1960s through the early 1970s — it is reasonable to expect increasing levels of drug use.

The heroin supply is of high purity and affordable. According to the Drug Enforcement Administration, the average purity of heroin available for retail purchase in the United States has quadrupled, from 6 percent to 24 percent, in the last five years. And growing supplies of pure heroin have led traffickers to cut the street price (in some areas to as low as $5 to $10), making it more affordable.

Although the presence of these conditions is cause for real concern, the fact that other conditions necessary for a heroin epidemic are absent suggests that an epidemic may not occur. Heroin is, and is perceived to be — even by addicts, a highly addictive drug with serious medical consequences. Further, there is a growing intolerance of drug use in this country. In recent years, the High School Senior Survey[3] has indicated that more and more students view illegal drug use unfavorably. Indeed, an enlightened public has denormalized all drug use, acknowledging that drugs are dangerous and that to use them is to risk losing one's job, health, and family.

The recent cocaine epidemic provides an instructive contrast. Today, most Americans are aware of the medical consequences of drug use. But the cocaine epidemic occurred, in part, because many segments of society in the 1970s considered cocaine use to be safe and nonaddictive, if not actually fashionable. In fact, many nonaddicted cocaine users gave the appearance of being able to handle their drug use while leading a normal life with a still-intact family, social, and work life.

Heroin is different. Far from being seen as fashionable, heroin — even when compared with other illegal drugs — is widely recognized as highly addictive and isolating. Further, heroin users are not effective "peer influencers." Long-term heroin addicts are more likely to be isolated from nonusers and, knowing the pitfalls of heroin addiction, may hesitate to expose others. Moreover, because of their generally low socioeconomic status and association with AIDS, hepatitis, and other illnesses, they present an unappealing picture of the negative consequences of heroin use.

Higher purity levels facilitate intranasal or inhaled administration. This could reduce the stigma associated with intravenous administration and heroin could become popular among some groups and in some communities. To date, however, there are no indications of a dramatic increase in new initiates, even in the face of apparent increased heroin availability. Vigilance, however, remains the watchword.

HEROIN USE PATTERNS

It is reasonable to conclude that increased heroin availability, rising levels of purity, and falling prices will lead (and may have already led) to increased heroin use. If, as some claim, we are at the onset of a heroin epidemic, we would expect to see epidemiological evidence of a substantial increase in the number of users, especially in the number of young users with little or no prior drug experience. Such evidence is important because this would portend a substantial increase in heroin use.

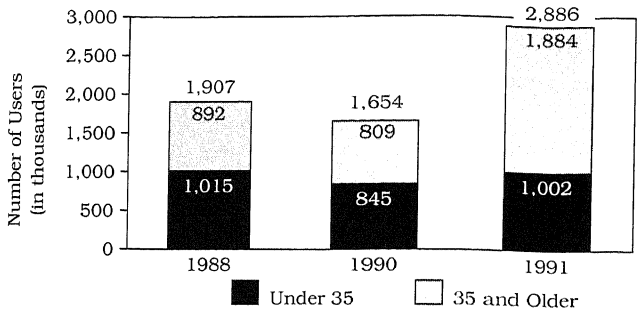
Level of Use

At first glance, recent data from the National Household Survey on Drug Abuse[4] and the Drug Abuse Warning Network[5] (DAWN) would seem to indicate a substantial increase in heroin use. According to the Household Survey, the number of lifetime[6] and annual users increased by 75 percent and 49 percent respectively between 1990 and 1991 (Figures 1 and 2). But these estimates provide a striking example of the danger of comparing year-to-year data, particularly heroin use data. First, the 1991 Survey shows about 1.2 million additional lifetime users between 1990 and 1991 l). Clearly, these 1.2 million people must ed heroin for the first time in 1991 and e reflected in annual user data (Figure 2). data show that there were only 701,000 annual users in 1991. In short, apparent changes in the number of lifetime and annual users are contradictory.

Second, the 1990 estimate of lifetime heroin users is 253,000 *fewer* than the 1988 estimate. Either a quarter of a million heroin users forgot to report (or lied about) previous heroin use, or they died. If the latter, their deaths would be reflected in DAWN statistics (when death is attributable to heroin use) or in Center for Disease Control statistics (when death is attributable to AIDS). But these two sources do not suggest that such deaths approached 253,000.

Figure 1

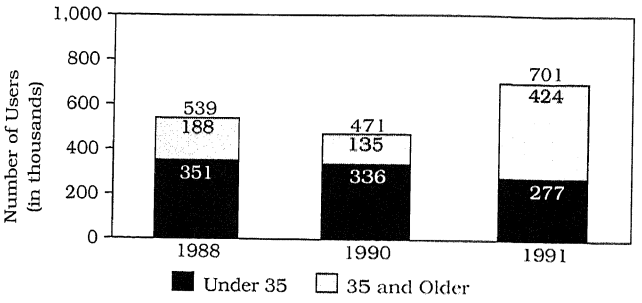
Lifetime Users of Heroin, 1988-1991



Source: NIDA National Household Survey on Drug Abuse, 1991.

Figure 2

Annual Users of Heroin, 1988-1991



Source: NIDA National Household Survey on Drug Abuse, 1991.

It appears, then, that the Surveys may have underestimated heroin users in 1990, thereby exaggerating the year-to-year change. The Department of Health and Human Services is undertaking analyses to try to account for the anomalies in the data. The explanation for these apparent anomalies may lie in the surveys themselves. The number of survey respondents who report using heroin is extremely small, primarily because the incidence of heroin use is so low, in addition to which heroin addicts are often socially isolated and beyond the reach of standard data collection methodologies, such as are used in the Household and High School Senior Surveys. Thus, year-to-year changes (or even changes over several years) in survey estimates of heroin users are often not statistically significant; indeed, they are highly unreliable.

Nevertheless, since the Household and Senior Surveys have been conducted for over 15 years with a consistent interview methodology, survey data — combined with information from other sources — can be used to discern trends over time.

Heroin users are more likely to show up in hospital emergency room and criminal justice surveys than

they are in household or school surveys. After steadily declining since the third quarter of 1989, DAWN heroin-related emergency room mentions increased in the first three quarters of 1991 (Figure 3). If these data reflected the medical consequence of heroin use by new initiates, this would be alarming evidence of a possible heroin epidemic. Although some of the heroin mentions may represent first-time or experimental users whose inexperience with drugs leads to a serious medical emergency, most drug researchers agree that the majority reflect experienced, older drug users at the peak of their consumption who are appearing in emergency rooms primarily for medical conditions, rather than overdose, associated with long-term drug use, particularly injection.

Another indicator of heroin use trends is the Drug Use Forecasting (DUF) program, which measures the rate of drug use among arrestees in a number of major metropolitan areas.[7] Although it is not a representative sample, DUF data nonetheless serve as an important barometer of drug use in large metropolitan cities. DUF data show a relatively stable heroin use pattern over time (although inexpensive heroin may obviate the need to commit crimes to pay for it). In fact, in the 18 cities where three consecutive years of DUF data are available (1988, and 1990), 15 of them — including New York ...attan), Fort Lauderdale, Dallas, Phoenix, ...phia, and Los Angeles — showed steady or ...rd trends in heroin use. The same pattern ...it in the first two quarters of 1991: the per... arrestees testing positive for heroin was sta... ...ss most of these cities, with the exception of ...Philadelphia, and St. Louis, which all expe... light increases.

Users

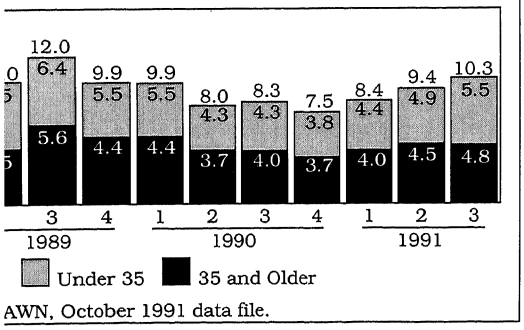
...educe the economic barriers to experi... ...y new users, while high purities facili... tate intranasal or inhaled administration and reduce the fear of injection. These factors are cause for concern because they could encourage experimentation by new users with little or no prior drug use.

There are scattered anecdotal reports of new heroin initiates. However, there is no evidence that these new initiates are sizable in number. The High School Senior Survey reported that the number of lifetime and annual heroin users among high school seniors in 1991 decreased by 31 percent and 20 percent respectively (Figure 4). This does not rule out the possibility of new heroin initiates among school dropouts, the homeless, and other populations not captured by the Household and Senior Surveys. However, heroin users with those characteristics do show up more often in surveys that capture the health consequences of drug use or entrance into the criminal justice system or the treatment community. But as discussed below, none of these indicators reflects a substantial number of young, new initiates to heroin at this time.

An absence of young initiates invites the question, who is consuming additional heroin supplies? Assuming these supplies are not being stockpiled for later sale (highly unlikely), the answer appears to be two groups of current drug users. The first group, current heroin users, appears capable of building up a substantial tolerance to heroin. A cheaper, more pure (and hence, snortable) heroin may cause this group to increase the size of each dosage, the frequency of episodes, or both.

The second group comprises current cocaine users. Heroin users usually "sequence" many drugs before using heroin. In fact, fewer heroin users than ever before report starting their heroin "career" without first using cocaine (Figure 5). As past National Drug Control Strategies have warned, heroin use could increase in the years ahead as some heavily

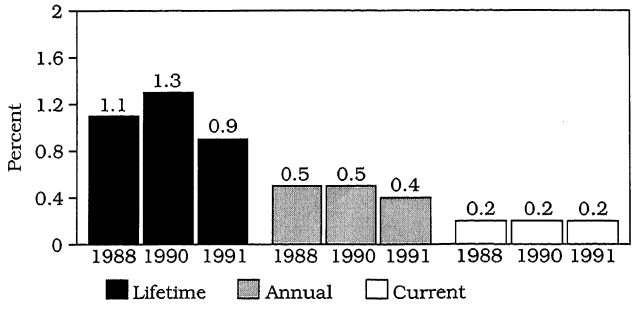
...ted Emergency Room Mentions,



...AWN, October 1991 data file.

Figure 4

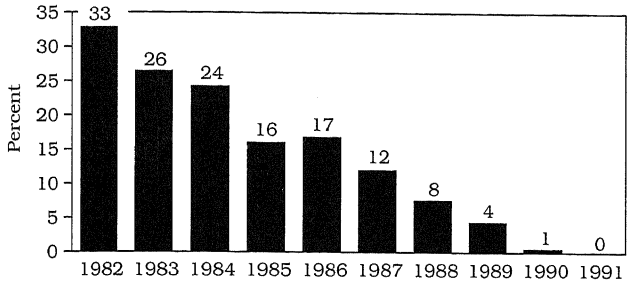
Heroin Use by High School Seniors, 1985-1991



Source: NIDA High School Senior Survey, 1991

Figure 5

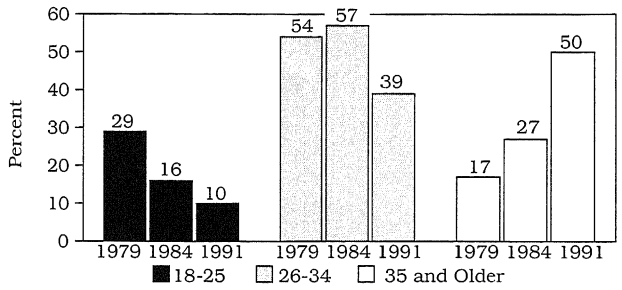
Users Beginning Their Heroin "Career" Before First Using Cocaine, 1982-1991



Source: NIDA Client Data System, 1991

Figure 6

Age at Treatment Admission (Heroin Users), 1979-1991



Source: NIDA Client Data System Files, 1991

addicted cocaine users employ sedatives such as heroin to modulate the peaks and valleys of their addictive use of cocaine, a stimulant. This "sequencing" could be made even easier by falling heroin prices and the availability of a snortable form of heroin.

The data also show a group of aging drug users gradually making its way through various age categories in the surveys. And this group is having a significant impact on drug use figures, including heroin. For example, in 1991, those 35 and over ıstituted 65 percent and 61 percent respectively he total lifetime and annual heroin users respec- up from 47 percent and 35 percent in 1988 es 1 and 2). Those over 35 continue to ıt for about half of the heroin-related emer- room mentions (Figure 3). And DUF data ıt, through 1990, males over age 36 tested or heroin in larger proportions than any group.

there is long-term evidence that new initi- niates are older. According to NIDA's ı System,[8] an increasing percentage of s admitted to treatment are aged 35 and younger age

heroin addiction. Within the next few years, we should have available for wide use medications such as LAAM, a longer-acting alternative to methadone; depot naltrexone, a long-acting heroin blocker; and buprenorphine, a medication that potentially combines the therapeutic effects of both methadone and naltrexone in a single medication and which may be a useful treatment for heroin addiction and dually-addicted cocaine addicts.

We are also enhancing our ability to collect and analyze data on national trends in heroin use. Several ONDCP initiatives give high priority to the heroin situation to ensure a timely and effective response to changing drug use patterns. ONDCP is coordinating an interagency heroin trafficking assessment, a National Heroin Situation Analysis to ensure the availability of the most accurate information and to identify new areas for research, and ongoing surveys to provide an early warning about national trends.

Prevention and Treatment

The threat of widespread heroin use in the 1990s is a good example of why long-term prevention and treatment efforts are needed. Indeed, one of the most important goals of the Strategy is to prevent Americans, especially the young, from ever using drugs. For those who have started, the goal is to get them off drugs and help them stay off. We already know a great deal about the treatment of heroin addiction and the treatment system remains more geared to heroin treatment than to any other kind of drug dependence.

The President's 1993 budget requests a total of $295 million, or 7 percent of the total demand reduction budget, for efforts that focus on reducing the demand for heroin, including outreach and prevention of intravenous drug use; a portion of the ADMS Block Grant[9] for prevention, outreach, and

treatment; a portion of the Capacity Expansion Program[10] to treat heroin addicts; and funding for narcotics research.

Law Enforcement

The Federal government is stepping up enforcement efforts against heroin trafficking. Because about 56 percent of the heroin available for consumption in this country is imported from Southeast Asia, intelligence efforts will be focused on better identification and targeting of Asian trafficking organizations. Chinese, Mexican, Nigerian, Sicilian Mafia, and other trafficking groups who are increasing their importation of heroin into the United States will continue to be targeted.

Particular emphasis will be given to law enforcement efforts in New York City, the most significant heroin importation point in the United States and a major heroin distribution center. For example, a multinational intelligence and enforcement program targeting Asian heroin trafficking organizations will be established.

International

Actions are also being taken on the international level where the overwhelming amount of opium production and illicit opiate consumption occur (Figure 7). The U.S. government is:

- Enhancing domestic and international efforts to destroy trafficking organizations;
- Improving the ability to interdict shipments of heroin and the chemicals used to refine it;
- Continuing bilateral funding support for foreign government law enforcement projects, public awareness, and development activities;
- Concluding bilateral agreements such as a Mutual Legal Assistance Agreements, asset sharing, and extradition treaties, to enhance law enforcement cooperation; and
- Encouraging worldwide recognition of the health, economic, and national security threat posed by opium cultivation and heroin production and trafficking.

SUMMARY

The available evidence suggests the following conclusions:

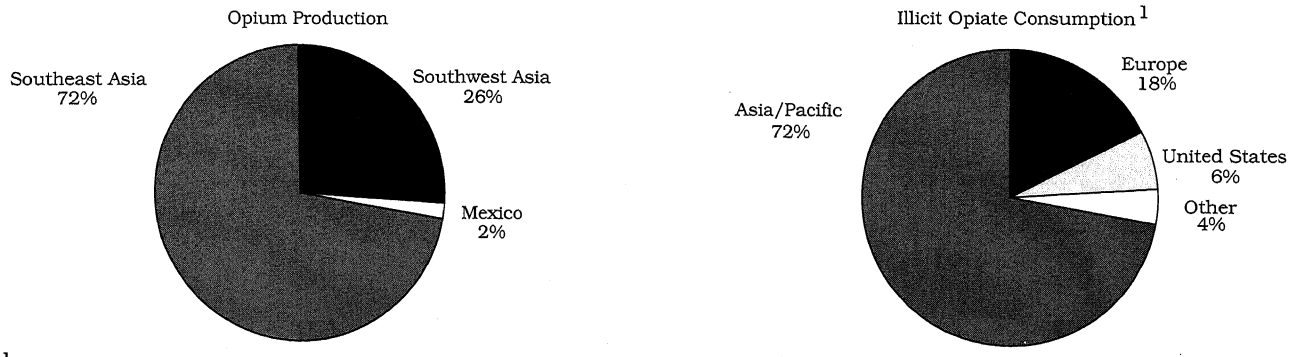
There is no evidence of a heroin epidemic. Because of society's intolerance of drug use in general and heroin in particular, and because the highly addictive and isolating nature of heroin is widely known, we are not seeing a substantial pool of new younger heroin users who would fuel heroin consumption to epidemic levels.

Nevertheless, heroin use is increasing. Increased heroin availability, higher purity, lower prices, and the availability of a snortable form of heroin are contributing factors to what appears to be increased heroin use among established heroin and cocaine users. We expect this condition to continue in the near term, primarily concentrated in certain areas of the country.

New heroin users are experienced drug users. Although some experimental use of heroin by those with little or no prior drug experience is expected, the bulk of new users continue to be current cocaine users who are "sequencing" to heroin to mitigate the effects of cocaine.

Figure 7

International Opium Production and Illicit Opiate Consumption, 1990



[1] Estimates of global consumption vary considerably
Sources: INCSR and ONDCP, 1991

Heroin users are an aging population. Those over 35 constitute the majority of lifetime and annual heroin users, DAWN heroin-related emergency room mentions, and arrestees testing positive for opiates in some cities.

Continued concern is warranted. The Federal government is intensively monitoring heroin availability, use, and consequence data and is taking aggressive actions on a number of fronts to be prepared in the event heroin use statistics rise significantly.

Endnotes

1. The Office of National Drug Control Policy acknowledges the contributions of the Special Projects Group of the Department of Health and Human Services and the BOTEC Analysis Corporation, whose recent "Heroin Situation Assessment" on heroin availability and use trends was of assistance in preparing this Bulletin.

2. BOTEC conducted interviews in Atlanta, Boston, Chicago, Denver, Detroit, El Paso, Houston, Los Angeles, Miami, New York, Oakland, San Diego, San Francisco, Seattle, and Washington D.C.

3. The annual High School Senior Survey is the leading indicator of drug use and attitudes toward drugs among our Nation's high school seniors.

4. The annual National Household Survey on Drug Abuse is the broadest measure of drug use in the Nation.

5. DAWN monitors the number and patterns of drug-related deaths and emergency room cases across the country.

6. "Lifetime use" is defined as use of heroin at least once in the respondent's lifetime.

7. Arrestees in selected cities are surveyed only in central booking facilities and on a volunteer basis. Because DUF is not a representative sample of either cities or arrestees, results cannot be projected to other U.S. cities, or even to the total arrestee population within each city.

8. National Institute on Drug Abuse Client Data System, 1991. The System uses data from treatment facilities in six cities (Boston, Dallas, Detroit, Houston, Miami, and New York). The findings may not be generalizable to the Nation as a whole.

9. The ADMS Block Grant program provides funding to mental health, drug abuse, and alcohol programs for treatment and prevention services. Over 50 percent of the block grant funds are used for drug related activities, including treatment of people with comorbid alcohol and drug problems. Current law requires States to use at least 50 percent of their drug allotment to treat intravenous drug users.

10. The Capacity Expansion Program provides funding exclusively for drug treatment services. Funds are distributed to States through competitive grants. Grants are made to States in which the demand for drug treatment services exceeds the capacity of the organizations in the States to provide such services. States may develop proposals to target particular groups facing a shortage of services, including intravenous drug users.

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